ALASKA MEDICAID
PHARMACY AND THERAPEUTICS COMMITTEE

Location of Meeting
550 W. 7th Avenue, Atwood Building, Room 240

MINUTES OF
January 16, 2004
8:00 a.m.
Final approved on March 19, 2004

Committee Members Present:
Terry Babb
Richard E. Brodsky
Michael Boothe
Heidi Brainerd
Robert H. Carlson (telephonic)
Traci Gale (telephonic)
Nathaniel Haddock (telephonic)
Charlene Hampton
Arthur S. Hansen
R. Duane Hopson
Diane Liljegren (telephonic)
Linda Miller (for Representative Peggy Wilson)
Ronald J. Miller
Michael C. Norman
Gregory R. Polston
Richard C. Reem
Janice L. Stables
George Stransky
Alexander H. vonHafften
Trish D. White (telephonic)

Committee Members Absent:
Kelly C. Conright
John T. Duddy
George S. Rhyneer
Robert D. Skala

Others Present
Dave Campana
Sandy Kapur
Julien Naylor

I. CALL TO ORDER:

David Campana called the meeting to order at 8:03 a.m. The demographic information on the Medicaid population that was requested at the last meeting was contained in the informational packet. The beneficiary information shows the growth in eligible recipients from 1998 to 2002, expenditure percentages for the four main Medicare eligibility groups and the ethnicity of the recipients.

He clarified that the committee was not developing a formulary, but a preferred drug list. A formulary contains drugs that are covered and not covered whereas the preferred drug list contained drugs that are preferred and non-preferred. Non-preferred drugs can still be obtained by the prescriber noting the medical necessity on the prescription. The preferred drug list will contain both generic and name brand drugs, but since we are aiming at overall savings for the Medicaid program, generic drugs should be used whenever possible. The meeting was turned over to Dr. Brodsky, who was appointed as the chairman of the Medicaid Pharmacy and Therapeutics Committee by Commissioner Joe Gilbertson.

Dr. Brodsky welcomed everyone to the meeting.

II. ROLL CALL:

The roll call was taken and a quorum was present with the above noted members.

III. PUBLIC COMMENTS:

Chairman Brodsky opened the meeting to public comments.

Aldone Smith, regional scientific director for Novartas, discussed the product Starlix. Post-prandial hyperglycemia has been associated with an increased risk of microvascular and macrovascular complications. The risk of cardiovascular diseases and all-cause mortality increases with increasing post-prandial glycemic values. Intervention is aimed at mealtime hyperglycemia and is important in reducing diabetic complications. Specific intervention includes Starlix, which is known by its generic name Nateglinide. It is a defenalalidine derivative that acts directly on pancreatic beta cells to stimulate insulin secretion. Dosing is 120 milligrams taken before meals. It has controlled mealtime hyperglycemia resulting in approved overall glycemic control with a minimal risk of hyperglycemia. Starlix is indicated for patients with type 2 diabetes that had not been chronically treated with other agents. Starlix is also indicated as a combination therapy with either metformin or thiazolidinediones. Combination therapy with Starlix addresses both defects and imperative secretion as well insulin resistance. The safety profile indicates that it is well tolerated with low rates of hypoglycemia and GI tolerability, comparable to that of placebo. No special monitoring or titration is required with Nateglinide as far as dosage. There are no clinically significant drug interactions. There is no necessity to reduce the dosage for special populations such as the elderly or patient with renal impairment or mild hepatic impairment. Starlix shows lower rates of hyperglycemia, no dosage adjustments for patients with renal impairment and lower weight gain. Starlix has reduces HbA1c alone and in combination with metformin or thiazolidinediones, complementary action to metformin and glitazones, safe and well tolerated, low incidence of hypoglycemia and simplicity of dosing and administration formulas.

Gary Scheiter, Novartas, said the name brand ACE Inhibitor drug Lotensin would go generic in early February. He asked the committee to consider adding Benazepril to the preferred drug list, as well as reviewing the issue adding Lotrel, which is a combination of Amlodipine and Benazepril. Combination therapy is critically necessary per J&C Guidelines for hypertensive patients to reach their goals.

Mike Abaddessa, Takeda Pharmaceuticals, discussed the beneficial effects of Actos, a thiazolidinediones (TZD) agent, and asked the committee to add Actos to the preferred drug list for qualified type 2 diabetic patients. Actos is indicated as an adjunct to diet and exercise to improve glycemic control in type 2 diabetics. Actos is indicated for monotherapy and in combination with metformin. It is the only thiazolidinedione indicated for use with all marketed dosage trends. Only the

thiazolidinedione class improved the core defects present in type 2 diabetics, improving insulin resistance and beta cell dysfunction. Both thiazolidinediones have excellent long-term sustained glycemic durability and efficacy. Both thiazolidinedione manufacturers are committed to studying the effects of the drugs in this class and the prevention of cardiovascular disease. There are three distinct clinical advantages to Actos including positive lipid protein effects, daily dosing and no clinically significant drug interactions. Cardiovascular disease causes approximately 75% of the deaths in type 2 diabetics. One out of two diabetics have cardiovascular disease at the time of diagnosis for type 2 diabetes. Type 2 diabetes, insulin resistance and the metabolic syndrome all have in common an athrogenic distopedemia characterized by elevated triglycerides, decreased HDL and although the LDL cholesterol is not necessarily elevated, there is a shift to a small and denser LDL that is more oxidizable and athrogenic. Actos monotherapy and combination therapy control trials showed the placebo controlled corrected values, decreases in thyglycerid up to 26% and HDL increases up to 13%. We have approximately 11 investigator initiated lipid evaluations, both prospective and retrospective, comparing the lipid effects of the agents in this thiazolidinedione class. The authors in these studies concluded that Actos delivered superior lipid effects at comparable doses. Besides the effective glycemic control, Actos had a positive effect to diminish athrogenic, distopedmia and type 2 diabetes. Actos is the only true once daily dose thiazolidinedione that allows optimal therapeutic efficacy. Actos is metabolized through multiple forms in a setachrome P450 system. This is a distinct advantage when a multi-drug therapy is necessary such as for type 2 diabetes. When a metabolic pathway is affected by another drug, the metabolism of Actos adapts to maintain its therapeutic efficacy without clinically relevant drug interactions. The FDA recently approved a change in the safety profile of Actos, which reflects a body of evidence showing no clinically relevant liver toxicity at therapeutic doses. Actos, as an insulin sensitizing agent, improves insulin resistance and beta cell function, is dosed once daily, improves lipid profiles of type 2 diabetics and has no clinically relevant drug interactions.

Jay Mouser, Aventis Pharmaceuticals, said he was a diabetes scientific manager with Aventis for three years and a clinical pharmacist for 21 years with a sub-specialty in endocrinology metabolism and nutrition. He discussed Lantus, insulin glargine, and Amaryl, sulfonylureas. Lantus is truly a basal insulin that is distinguishable by its pharmacokinetics and its dynamic properties. It lasts 24 hours, is injected once a day and has no pronounced peaks. A peak in the insulin of diabetic patients causes hypoglycemia. Many recent studies comparing Lantus with MPH shows a decrease in hypoglycemia of 20% to 48% in both type 1 and type 2 patients. Insulin glargine has a very low rate of hypoglycemia. Hypoglycemia is very expensive to treat and we have cost data showing the benefits of Lantus as compared to MPH in Medicaid populations. The California Medicaid populations had a cost saving of $69 every six months, per patient, when they were switched from MPH to glargine. Much of the cost savings came from the decreased hypoglycemia. A study published in July of 2003 in Manage Care Interface showed that the cost of a hypoglycemic event where the patient accessed the health care system was $1,186. A paper will be shown at the Manage Care meeting in March that shows when patients have switched from MPH to Lantus, the savings more than makes up for the additional cost of the product. Amaryl's unique mechanism of action should be given consideration. Amaryl has some differences in receptor binding issues, which leads to some very impactful benefits to patients with diabetes. Hypoglycemia is considerably less with Amaryl compared to Glyburide. 30,000 patients that were study in Germany over a three-year time period showed the incidence of hypoglycemia where patients accessed the emergency room was seven fold greater with Glyburide compared to Amaryl. Amaryl is the only sulfonylurea that has proven first phase insulin release.

Kathy Geissel declined to testify.

Debra Bowers, a registered nurse and clinical specialist for Roche Laboratories, discussed Pegasys combination therapy, which is currently the standard of care in the United States. Pegylated interferons were developed to improve the PTA parameters of standard interferon. In the case of Pegasys, the 40kd molecule has improved the pharmacokinetics such that the concentrations last beyond the 168-hour mark, which is one-week dosing interval. The pharmacokinetics provide that this product can be in solution and stable for up to 18 months, because of its PK parameters, which is a fixed dose product that is one dose for all patients. This is a great benefit for both patients and clinicians. Genotype 1 patients are the most difficult types to treat in the world. Fifty percent of the United States is genotype 1, high viral load. The first published clinical trial for Roche had a comparator arm of standard interferon and Ribavirin. There are no head to head clinical trials with the pegylated interferon, so the only fair way to compare the data is to compare the two products. In the first clinical trial, Pegasys and Ribavirin was significantly superior to standard Interferon and Ribavirin for both genotype 1 and genotypes 2 and 3. In addition, when Roche broke down the products to look at high viral load, both high viral load and low viral load drove the statistical significance of the efficacy of Pegasys plus Ribavirin. Pegasys plus Ribavirin had a 41% efficacy in genotype 1 high viral load as compared to 33%. In addition, Roche has conducted a second clinical trial that will be published in Annals of Internal Medicine in March of 2004. In this clinical trial, we were prospectively looking at duration of therapy and Ribavirin dose. We clearly demonstrated that in genotype 1 patients you needed a full year of therapy and higher doses of Ribavirin of 1,000 to 1,2000 milligrams. Genotype 1 high viral load patients achieved a 46% sustained viro-logical response. In the labeling for the Pegasys, the FDA combined the data and gave Pegasys plus Ribavirin a 43% genotype 1 high viral load SVR, which is the highest of any other products in FDA approved labeling. We also looked at treatment duration and Ribavirin doses. We demonstrated that for genotypes 2 and 3, you really only needed six months of therapy and 800 milligrams of Ribavirin. That was compelling enough data that it was included in the INH consensus statement on the treatment of hepatitis C. This would be a cost savings for Alaska Medicaid as well as a benefit for patients and clinicians. The patients would have shorter treatment periods and fewer adverse events.

Androj Maciejewski, discussed the treatment of diabetes. Over the last 13 years, he has noted an epidemic of diabetes in western civilization, especially type 2 diabetes. There is no successful treatment to reverse diabetes, so we will be facing very serious complications and issues in health care in that regard. We treat diabetes with a variety of agents, including thiazolidinediones. Rosiglitazone (Advandia) is a similar agent to Actos. He felt it was imperative to have at least one thiazolidinedione on the preferred drug list, because this agent reverses the potogensis of diabetes type 2. The other agents, including insulin, treat the existing problem of elevated sugar and does not address the issue of reversing the resistance to insulin. There are tremendous long-term advantages including better glycemic control and prevention of diabetic nephropathy. Advandia is included in the group of drugs that treat vascular problems. An advantage Advandia has over Actos is it is in combination with Glucophage, which is more cost effective than other agents. Advandia works slowly and the effect is visible after a month, with further results after six months of therapy. He treated all his type 2 diabetic patients with either Advandia or Glucophage.

DOUG COOK, Alaska representative for GlaxcoSmith Kline, discussed Coreg, which was placed on the preferred drug list, but would be re-reviewed.

Chairman Brodsky said the board would discuss delaying the re-review of Coreg, because the committee had not had a chance to vote on the issue.

Doug Cook said the committee should keep the definition of heart failure in mind when reviewing Coreg. Renal heart failure, according to the American College of Cardiology and the American Heart Association, is now classified as A, B, C and D. Class A and B heart failure patients are predisposed to diseases such as longstanding hypertension, diabetes and any type of cardiomyopathy. Coreg is the only cardiovascular product with indications for all these. He reviewed some of the advantages of Coreg as outlined in the American Journal of Hypertension. Coreg lowers blood pressure across all ages and ethnicity groups, reduces total resistance, does not reduce cardiac output, does not effect renal patients, has a neutral affect of lipids and glucose, has wide tolerability, reduces morbidity, and reduces the length of hospital admissions. Coreg also has antioxidant properties greater than large doses of vitamin E. Coreg is usually reserved for the patient that has been uncontrolled or has underlying conditions to develop heart failure.

Bill Baxter discussed Toprol XL, which is cardio-selective beta-blocker that has an affinity for the beta 1s, which are in the heart, as opposed to the beta 2 receptors, which are in the lungs. This can convey a margin of safety for those patients that are predisposed to asthma. Toprol XL is dosed at one tablet a day. Other drugs will sometimes lose their hypertensive action at the end of their dosing interval and will have to be dosed again in a 24-hour period to maintain the patient's blood pressure. Toprol XL takes the diastolic pressure and reset it at a lower level over the 24-hour period. Toprol XL's main indications are for hypertension, angina and heart failure. Toprol XL significantly reduces mortality, morbidity and hospitalization, particularly for patients with heart failure. Toprol XL can be used in combination with ACE Inhibitors and diuretics, with or without Digoxin, which has been demonstrated in the MERIT HF trial. Toprol XL is one of the few beta-blockers that is actually indicated for heart failure. The MERIT HF trial was a randomized placebo controlled trial in which Toprol XL was compared to placebo and this was added to standard heart failure therapy. The patients were triturated up in dosage and they found that the risk reduction was 34% for all cause morbidity and mortality. There was a 19% reduction in all cause mortality plus all cause hospitalization. There was a 38% reduction in cardiovascular mortality and 41% reduction in sudden death. Toprol XL is different from other generic beta-blockers in not only the dosing, but also the number of indications it has. He asked the committee to continue to support Toprol XL and have it remain on the preferred drug list in 2004.

Paul Worrell, MD said he was on the Board of Trustees of the Alaska State Medical Association. The Alaska State Medical Association did not have a specific position, but he would make some general comments. He felt the system for prescribing non-preferred drugs was too complicated and needed to be simplified. The Alaska State Medical Association agreed to work with the state because of the initial assurances that the system would be easy to use. He did not like the concept that First Health would make this system work by threats. About six years ago the state informed us that they were going to do audits of people's Medicaid behavior to see if their chart documentation matched the charges. The state went to about 100 physicians' offices and went through their notes and insinuated that half of the physicians had overcharged Medicaid by fraudulent means. The state assessed dollar amounts that had to be paid back by the physicians. Before the audits, about 95% of the physicians in Alaska were working with Medicaid, but now there are only about 50%. The state was planning a new round of audits in the near future. The new rules would allow the state to force this on physicians and they would have almost no right of appeal. The net effect of this is another 15% of the physicians that cooperated with Medicaid would be lost in the next year, which would mean only one-third of the state's physicians would be working with the Medicaid program. He felt the committee needed to work more closely with the physicians in the state. The physicians do not need the Medicaid business. The Medicare population is having a difficult time obtaining access to physicians and we do not want the same thing to happen to the Medicaid population. He asked the committee not to let First Care develop systems where they

could come into the physicians' offices and audit their charts if they felt the physicians were not cooperating. First Care stated they would provide the physicians with "educating lessons" if they were not in compliance, but he did not feel they would stand for that. He was also concerned that the committee was allowing too few choices of drugs into each category.

Eric Beresford, Schering-Plough, discussed hepatitis C and the differences between PEG-Introns and Pegasys. People are becoming more aware of hepatitis C, the treatment options and the fact that there are multiple classes and drugs within each class. We are seeing a growing incidence of hepatitis C. Due to the slow growth of the virus, people may not know they are infected until they actually have fibrosis or liver decomposition. He discussed some of the positive predicted factors of success and what factors would have a longer, sustained viral response from one drug versus another. If you are a female or a non-genotype 1, you have a better chance of having a longer sustained viral load on a pegylated interferon. In Alaska, about 50% of the population is genotype 1 with the remaining 50% being genotype 2 and 3, which has a very high success rate. Dr. Davis and Dr. McKutchinson has shown that if a patient is 80% adherent to the Interferon dose and the right viron dose, there will be an 80% chance that they will remain virally suppressed in the long term. Unfortunately, there are only two products that treat this disease. Pegasys is a drug that is pegylated with multi branches and increases the half-life, but it's also a heavy molecule. The weight of the molecule is 40kd. When you look at PEG-Intron, it has one string of pegalation attached to it and the weight of the molecule is only 12kd. The difference in size means it's not as noticeable to the body. The patient will not have as much immune reaction and the half-life of the drug will be different, so the patient will see a difference in early viral response and sustained viral response. Schering-Plough feels so strongly about this that we are going ahead with a head-to-head trial called IDEAL in which we are going to compare the two products, as well as comparing them with increasing doses of Ribavirin. The final decision will come down to which pegylated interferon product is superior. What studies have shown individually is that Pegasys has an earlier viral response in the beginning, but the sustained viral response is shorter. PEG-Intron has a shorter onset of viral response, but a longer sustained viral response. This means that if you have patients that do not know that they have hepatitis C, they come into hepatitis C positive, you treatment with PEG-Intron, their sustained viral load is going to be longer in the long term. There will fewer incidents of liver transplantation, less incidence of fibrosis and less incidence of elevated liver enzymes. He discussed when one dose of medication was right for all patients.

Chairman Brodsky noted that the minutes from the last meeting had been distributed to the committee, but copies were not at the meeting. Dr. Carlson had not been on teleconference at the last meeting as indicated by the minutes. The minutes from November and January would be reviewed and approved at the February meeting.

IV. INSULINS

Chairman Brodsky introduced Julien Naylor, who has been with the Native Health Program in Alaska for several years and specializes in diabetes. She will be available to provide expert opinions in the area of insulin as requested by the committee at the last meeting.

Sandy Kapur, an employee of First Health Services Corporation, said she wanted to make it clear that First Health was a non-threatening company. They do a great deal of education and work with the State to insure that program run smoothly. She and many of her friends were pharmacists, so she always considered how the program would affect them. Her father, uncle and cousin are all physicians and she

would not work for a company that would not force them to do something that they did not want to do. First Health implemented programs were easy and allowed physicians to care for more patients.

Sandy Kapur said the insulins were difficult to review, because there were a number of agents. The insulins were divided into the analog and non-analog agents. The non-analogs are the older insulins, which have the exact same amino acid sequence as endogenous insulin. The difference is in the vehicles the agents are suspended in, which changes their kinetics, onset, duration and action. The analog agents are the newer agents that have come about in the last five to six years where the amino acid sequence of insulin has been changed or altered so as to change the kinetics of the drugs. The committee will only review the Humulin R agents. There are two major product lines for non-analog agents, Eli Lilly and Novo Nordisk. The three major insulins are the bolus insulins, which are the regulars and are exemplified Humulin R and Novolin R; a basal insulin called Humulin N, which is an intermediate or somewhat long acting agent, and its comparator Novolin N; and a premixed combination of Humulin 70/30 and Novolin 70/30. The product lines by Eli Lilly and Novo Nordisk are exemplified by their identical amino acid sequence and are deemed equal in the RN and 70/30 premix categories. The product line may be used interchangeably in a 1-to-1 unit conversion. It is not recommended that the product lines be interchanged, so a Humulin N cannot be used with a Novolin 70/30. Providers with patients on complicated regimens or those patients in which a change would be thought to be detrimental to their care will simply place the phrase "complex regimen" or "change inappropriate at this time" on the prescription face such that the PA would be authorized by the dispensing pharmacist for the non-preferred agent. We wanted to make it easier for patients to obtain raw insulins, but we made the recommendation that one product line could be chosen if these agents were considered clinically equivalent.

Dr. Naylor pointed out that dealing with diabetics and insulin was complicated so it was important to simplify the prescription process. If the agents were deemed equivalent, it would be nice to see both lines on the preferred drug list to decrease complications in the prescribing. She felt it was important that all three levels of agents were represented on the preferred drug listing.

Chairman Brodsky said the committee needed to decide whether or not the two agents were equivalent. Once the equivalency decision was made, the drug companies would have the opportunity to bid on the price to have their drugs included on the preferred drug list.

In response to Heidi Brainerd, Sandy Kapur said the analogs must go with their corresponding Humulin or Novolin products.

CHAIRMAN BRODSKY CALLED FOR A VOTE ON WHETHER THE NON-ANALOG INSULIN GROUPS WERE EQUIVALENT. MOTION PASSED.

Ayes: Babb, Boothe, Brainerd, Brodsky, Carlson, Gale, Haddock, Hampton, Hansen, Hopson, Liljegren, L. Miller, R. Miller, Norman, Polston, Reem, Stables, Stransky, vonHafften, White.
Nays: None.

Sandy Kapur reviewed other non-analog agents that needed to be reviewed individually. Velosulin BR is made by Novo Nordisk. In November, Novo Nordisk decided that they would discontinue this product and supplies are expected to run out in April 2004. For that reason, we would like to make this a non-preferred agent, because patients would have to be switched over when the supplies ran out.

Humulin-L, which is an intermediate acting insulin, has no equal Novo Nordisk product, because Novolin-L was discontinued by the manufacturer. Due to the poor absorption and unpredictable kinetics of Humulin-U, it is recommended that this product be non-preferred.

Sandy Kapur said the last agent to be reviewed was Humulin 50/50 and there was no comparable Novo Nordisk 50/50 equivalent.

Dr. Naylor felt Humulin-U was an antiquated medication, because there were better choices available. She suggested making Humulin-U a non-preferred drug. Most people used a combination of 70/30, because of the breakdown and balance. Some elderly people may use the 50/50 combination, but that would probably be on an individual basis.

CHAIRMAN BRODSKY CALLED FOR A VOTE ON PLACING VELUSULIN BR BY NOVO NORDISK ON THE NON-PREFERRED LIST. MOTION PASSED.

Ayes: Babb, Boothe, Brainerd, Brodsky, Carlson, Gale, Haddock, Hampton, Hansen, Hopson, Liljegren, L. Miller, R. Miller, Norman, Polston, Reem, Stables, Stransky, vonHafften, White.
Nays: None.

GEORGE STRANSKY MOVED TO INCLUDE HUMULIN-L ON THE PREFERRED LIST. SECONDED BY TERRY BABB. CHAIRMAN BRODSKY CALLED FOR A VOTE ON THE MOTION. MOTION PASSED.

Ayes: Babb, Boothe, Brainerd, Brodsky, Carlson, Haddock, Hampton, Hansen, Hopson, L. Miller, R. Miller, Norman, Polston, Reem, Stables, Stransky, vonHafften, White.
Nays: Unidentified male, Liljegren, Gale.

JANICE STABLES MOVED TO PLACE HUMULIN-U ON THE NON-PREFERRED LIST. SECONDED BY GEORGE STRANSKY. CHAIRMAN BRODSKY CALLED FOR A VOTE ON MOTION. MOTION PASSED.

Ayes: Babb, Boothe, Brainerd, Brodsky, Carlson, Gale, Haddock, Hampton, Hansen, Hopson, Liljegren, L. Miller, R. Miller, Norman, Polston, Reem, Stables, Stransky, vonHafften, White.
Nays: None.

GEORGE STRANSKY MOVED TO PLACE HUMULIN-U ON THE NON-PREFERRED LIST. SECONDED BY JANICE STABLES. CHAIRMAN BRODSKY CALLED FOR A VOTE ON MOTION. MOTION PASSED.

Ayes: Babb, Boothe, Brainerd, Brodsky, Carlson, Gale, Haddock, Hampton, Hansen, Hopson, Liljegren, L. Miller, R. Miller, Norman, Polston, Reem, Stables, Stransky, vonHafften, White.
Nays: None.

Sandy Kapur moved on to the analog agents. Analog agents are made of human recombinant DNA origin, but their amino acid sequence has been restructured so as to change the kinetics of the agent.

The first agent to be reviewed Lantus, which is an insulin glargine solution by Aventis. Lantus was made by altering three amino acid sequences of human insulin, which makes its release rate constant and without peaks. It is a unique agent.

Dr. Naylor said there was no question that Glargine needed to be a preferred drug for type 1 diabetics. Lantus is now a cornerstone for type 1 diabetes treatment, because is has no peaks and makes management of type 1 diabetes much easier. In combination with an analog medication, it is considered to be as effective as the pump. This can be used in adults and children and should be considered the basal insulin for type 1 diabetic patients. In type 2 diabetes there are a lot of studies showing that NPH insulin and glargine are both effective. Oftentimes when a patient with type 2 diabetes is first transitioned to insulin, some bedtime NPH insulin can be helpful. There are problems with peaking for patients that have episodes of hypoglycemia on NPH insulin and transitioning to Glargine can help manage their day to day episodes of hypoglycemia.

Sandy Kapur reviewed the criteria for medical justification. Type 1 diabetics that were written a prescription for Lantus would be automatically authorized. Children, anyone 21 years of age or younger, would automatically be allowed Lantus insulin through a systems edit within the computer system. Patients currently on Lantus insulin will not be asked to change therapy, but patients with diabetes mellitus type 2 will be asked to try another basal insulin prior to utilization of Lantus.

In response to Richard Reem, Dr. Naylor said NPH insulins were less expensive than Lantus. In type 2 diabetes, oftentimes the transition to an insulin involves the first step of bedtime insulin to deal with the hyperactive liver at night, so the peak could be used to help with that. However, studies have come out showing that Glargine used at nighttime in type 2 diabetes also helps bring the sugars down in the morning. She felt it would be reasonable to have Glargine across the board for type 2, but there was a consideration for one step prior to changing to Lantus if the patient is experiencing hypoglycemia.

Diane Liljegren said she would like to see Glargine available as first line in type 2 diabetes. There are patients that have irregular eating and compliance problems when they transition to insulin and they tend to do better on a combination of Lantus and Lispro and would be a disaster on NPH regular.

DIANE LILJEGREN MOVED TO MAKE LANTUS AVAILABLE TO TYPE 1 AND TYPE 2 DIABETIC PATIENTS AS THE FIRST LINE INSULIN. SECONDED BY TERRY BABB. CHAIRMAN BRODSKY CALLED FOR A VOTE ON THE MOTION. MOTION PASSED.

Ayes: Babb, Boothe, Brainerd, Brodsky, Carlson, Gale, Haddock, Hampton, Hansen, Hopson, Liljegren, L. Miller, R. Miller, Norman, Polston, Reem, Stables, Stransky, vonHafften, White.
Nays: None.

Sandy Kapur reviewed the bolus insulins. Lispro is Humalog and Aspart is Novolog. Both agents are considered pharmacologically equivalent and could be interchanged for one another in a 1-to-1 exchange. Both agents can be used safely in subcutaneous pumps. The analogs must be mixed with the same line. Although only Humalog has the indication for use in children greater than three years of age, the ADA put out a position statement saying that both could be safely used in children. One agent could be chosen as preferred over the other in light of clinical equivalency. Providers with patients on complicated regimens or patients in which a change would be thought to be detrimental to their care will

simply place the phrase “complex regimen” or “change inappropriate at this time” on the prescription face such that a PA would be authorized by the dispensing pharmacist for the non-preferred agent.

In response to Terry Babb, Sandy Kapur said she could not comment on whether there was a recent study that showed that Aspart was more effective in pediatric populations. Dr. Buckley, our pediatric endocrinologist, had no preference, but felt at least one of them needed to be on the preferred drug list.

In response to Terry Babb, Dr. Naylor said she never triturated insulin in half units, because it was very difficult for patients to draw up half units. She had not had any problems with either of them triturating them up. She felt they needed an analog insulin on the preferred list. The combination of Glargine with an analog insulin is the optimal multi-injection regime for type 1 diabetics and it also has a very important role in type 2 diabetics. Analog insulin allows a patient to inject themselves right before their meal whereas regular insulin has to be injected 30 minutes prior to eating and if the meal is late then there is a risk of hypoglycemia.

In response to Chairman Brodsky, Dr. Naylor said the drugs were designed to be mixed with their own line. If you are mixing this with an NPH insulin, it has to be mixed with a dedicated brand.

GEORGE STRANSKY MOVED THAT LISPRO AND ASPART ARE EQUIVALENT AND AT LEAST ONE SHOULD BE ADDED TO THE PREFERRED LIST. SECONDED BY RICHARD REEM. CHAIRMAN BRODSKY CALLED FOR A VOTE ON MOTION. MOTION PASSED.

Ayes: Babb, Boothe, Brainerd, Brodsky, Carlson, Gale, Haddock, Hampton, Hansen, Hopson, Liljegren, L. Miller, R. Miller, Norman, Polston, Reem, Stables, Stransky, vonHafften, White.
Nays: None.

Sandy Kapur reviewed the premixed analog insulin combinations, which are partially a basal agent and partially a bolus agent. Novolog Mix 70/30 is made by Novo Nordisk and Humalog Mix 75/25 is made by Eli Lilly. The combination mixes are deemed very similar such that one agent could be chosen as preferred over the other. Changing therapy from agent must be done with great care and monitoring. The pediatric endocrinologist did not comment on either agent, because she did not generally use mixes in the pediatric population due to the changing insulin requirements of pediatric patients.

Dr. Naylor said they did not use these two mixes so she did not have a recommendation.

JANICE STRABLES MOVED THAT NOVOLOG MIX 70/30 AND HUMALOG MIX 75/25 BE CONSIDERED EQUIVALENT AND ONE OR BOTH SHOULD BE INCLUDED ON THE PREFERRED DRUG LIST. SECONDED BY ARTHUR HANSEN. CHAIRMAN BRODSKY CALLED FOR A VOTE ON MOTION. MOTION PASSED.

Ayes: Babb, Boothe, Brainerd, Brodsky, Carlson, Gale, Haddock, Hampton, Hansen, Hopson, Liljegren, L. Miller, R. Miller, Norman, Polston, Reem, Stables, Stransky, vonHafften, White.
Nays: One unidentified person.

V. FURTHER DISCUSSION ON ACEI'S AND BETA-BLOCKERS

Chairman Brodsky said the committee wanted to revisit the ACE Inhibitors and the beta-blockers that had been discussed at the last meeting to look at utilization and the cost of the recommendations. He felt this item should be postponed to the next meeting, because Dr. Rhyneer was not present. There were other cardiologists that had strong opinions on this issue and they were waiting for materials from them as well. He noted that the committee's job was to do clinical determinations to say which drugs should be included on the preferred list and then the financial issues would be dealt with. The feeling of the committee was that they had included people from various disciplines on the committee for various reasons. When we considered this drug, the cardiologist on the committee was not present and he had some strong opinions on this issue. He felt they should review the issue when the appropriate people were present at the meeting. It was his understanding that there was a significant cost differentiation. The HOPE trial indicated that Enalapril was superior in a sub class of patients with heart failure, but it had not been studied with other drugs. The proposal from Dr. Rhyneer was that the physician could write "HOPE trial" on the prescription pad and the drug would be approved even if it was not on the preferred list. There are also significant cost issues around Carvedilol and Toprol.

JANICE STRABLES MOVED TO POSTPONE THE FURTHER DISCUSSION ON ACEI'S AND BETA-BLOCKERS TO THE NEXT MEETING. SECONDED BY AN UNIDENTIFIED MALE.

Michael Boothe said it was his understanding that the committee would make clinical decisions and the finances would go along with the clinical decisions. He did not feel there was any point to him being on the committee if they were going to reconsider things and agree with the State's point of view on everything.

Chairman Brodsky said the committee's decision was the clinical decision as to which drugs should be included on the preferred list and whether or not the drugs were equivalent. Mr. Booth questioned the committee's role if they made decisions based on the State's economical issues. If the committee decided they should not review the ACEI's and beta-blockers then they should vote no on the motion.

Terry Babb said the committee added Ramipril to the preferred list at the last meeting, which was consistent with what the cardiologist had recommended. They had also added Coreg, which was consistent with the information provided by the cardiologist. According to the documentation received, that was still supported.

Janice Stables said the supplemental information questioned if Altace should be removed from the preferred list, except for physicians that believed their patients met the criteria for the HOPE trial.

Terry Babb felt they would be creating problems in terms making this an easy process to write a prescription for a Medicaid patient if they asked physicians to write "HOPE trial" on one prescription or "allergy" on another prescription.

Arthur Hansen agreed that they would be making the system too complicated if they put conditions on every medication they discussed.

Heidi Brainerd said she was strongly opposed to using an indication for therapy as in a name of a clinical trial. She felt it was much more sound to give a diagnosis and use a diagnosis code as opposed

to one trial, because there would be arguments on conflicting studies as well as the fact that there are new trial coming out every day.

CHAIRMAN BRODSKY CALLED FOR A VOTE ON THE MOTION TO POSTPONE THE FURTHER DISCUSSION ON ACEI'S AND BETA-BLOCKERS. MOTION FAILED.

Ayes: Unidentified person, Haddock.
Nays: Babb, Boothe, Brainerd, Brodsky, Carlson, Gale, Hampton, Hanson, Hopson, Liljegren, L. Miller, R. Miller, Norman, Polston, Reem, Stables, Stransky, vonHafften, White.

Chairman Brodsky said the drugs placed on the preferred drug list for ACEI's and beta-blockers at the last meeting would stand and the issue would not be reconsidered. He felt the committee had made a good decision. It was the committee's job to make clinical decisions and they should not be pressured by economic issues to reconsider their decisions.

The board took a break from 9:45 a.m. to 10:00 a.m.

VI. ORAL ANTI-DIABETIC AGENTS
Biguanides and Biguanides Combinations

Sandy Kapur said there was truly only one chemical entity in the biguanides class, which was Metformin, which is available as Glucophage or Metformin immediate release. There is Glucophage XR, extended release and its generic equivalent metformin ER, which just came out in December. Metformin liquid, Riomet, has just entered the market. The immediate release is the only agent that is FDA labeled and indicated for the pediatric population of 10 years and up. These agents have been shown to cause a weight loss, which has been advantageous in this group of patients. They also have been shown to have a positive effect on lipids and they may increase HDLs. They have also been shown to delay the onset of diabetes type 2 for patients with a glucose tolerance or impaired fasting glucose. These agents are indicated by the ADA as being first line agents in the treatment of diabetes type 2 in the pediatric population. The agents that we need to differentiate between in this class are the immediate release versus the extended release. The generic drug and syrup has just come onto the market.

Dr. Naylor said the syrup has been long awaited, because Metformin is a large pill. Both the immediate release and the extended release are widely used. The extended release was particularly useful for people who were having compliance problems, because it could be dosed once a day. It is also felt it has less GI side effects. If someone cannot tolerate the immediate release easily, they might tolerate the extended release better.

RICHARD BRODSKY MOVED THAT ALL THE DRUGS WERE EQUIVALENT IN CLASS AND THE PREFERRED DRUG LIST SHOULD INCLUDE AN IMMEDIATE RELEASE, EXTENDED RELEASE AND SRYUP. SECONDED BY AN UNIDENTIFIED MALE. CHAIRMAN BRODSKY CALLED FOR A VOTE ON THE MOTION. MOTION PASSED.

Ayes: Babb, Boothe, Brainerd, Brodsky, Carlson, Gale, Haddock, Hampton, Hansen, Hopson, Liljegren, L. Miller, R. Miller, Norman, Polston, Reem, Stables, Stransky, vonHafften, White.
Nays: One unidentified person.

Second Generation Sulfonylureas

Sandy Kapur reviewed the second generation sulfonylureas, which included Amaryl, Diabeta, Micronase, Glyburide, Glucotrol and Glipizide. Glucotrol and Glucotrol XL are now available generically.

Dr. Naylor said second generation sulfonylureas were an important tool in the treatment of type 2 diabetes. She discussed a couple of important considerations. With both (indiscernible) and Glipizide is they do not have active metabolites and can be used in renal patients, whereas Glyburide is discouraged in renal patients because it has an active metabolite. In the spirit of simplicity, the committee could recognize all of these drugs as being important in the treatment of type 2 diabetes. She did not feel the drugs were clinical equivalent, especially when looking at older patients over the age of 65 or patients that were on Glyburide has episodes of hypoglycemia.

Sandy Kapur said all the drugs in this class were available generically, except Amaryl.

AN UNIDENTIFIED MALE MOVED TO INCLUDE ALL THE SECOND GENERATION SULFONYLUREAS TO THE PREFERRED LIST. SECONDED BY AN UNIDENTIFIED MALE. CHAIRMAN BRODSKY CALLED FOR A VOTE ON MOTION. MOTION PASSED.

Ayes: Babb, Boothe, Brainerd, Brodsky, Carlson, Gale, Haddock, Hampton, Hansen, Hopson, Liljegren, L. Miller, R. Miller, Norman, Polston, Reem, Stables, Stransky, vonHafften, White.
Nays: None.

Alpha-Glucosidase Inhibitors

Sandy Kapur reviewed the alpha-glucosidase inhibitors, Glyset (generic Miglitol) and Precose (generic Acarbose). Alpha-Glucosidase inhibitors delay the digestion of ingested carbohydrates and decrease post-prandial blood glucose sugars as opposed to acting on the fasting blood glucose sugars. As a class, they are less potent than the oral sulfonylureas and the biguanides when used as monotherapy. They decrease hemoglobin A1C by 0.5% to 1%. They can be used as monotherapy. They can be used with a sulfonylurea. Precose can be used in combination with insulin and metformin. The NIDDM study showed that Precose could delay the onset of diabetes type 2 for patients with impaired glucose tolerance. It also showed that it may reduce the incidents of cardiovascular disease and hypertension for patients with impaired glucose tolerance. Both Dr. Naylor and Dr. Buckley agreed that both agents were excellent agents and comparable, but both agents cause a significant amount of GI side effects which limits their utilization. However, both agents are excellent as adjunctive therapy in those patients who can tolerate them. There are no major clinical advantages or disadvantages to having one agent preferred over the other.

Dr. Naylor said this was an intriguing classification of medication. It binds in the intestine reducing the amount of carbohydrates absorbed and as a result has bad GI side effects. There is a 25% dropout rate in the studies due to the GI side effects. The role is very clear in the prevention of diabetes for those who can tolerate it and as an adjunct therapy in diabetes that can really help even out the sugars. The problem is the drug has to be triturated very slowly over months rather than days or weeks to really become effective. With the interest in this classification, we really need to have one or the other added to the preferred drug list, because there are providers who have a lot of success using them.

In response to Mr. vonHafften, Dr. Naylor said from the ethnic background point of view there was a large study in China using Acarbose in pre-diabetes prevention. The Asian population seems to tolerate Acarbose much better than the Canadian and European populations, which had a 25% dropout rate. They were not sure why, but it could be due to dietary factors. It seems to promote weight loss through diarrhea. Rather than having a peak of carbohydrates, it help to slow it down the carbohydrate absorption down so the beta class can better deal with it.

GEORGE STRANSKY MOVED THAT GLYSET AND PRECOSE WERE EQUIVALENT AND A DRUG FROM THIS CLASS INCLUDED ON THE PREFERRED DRUG LIST. SECONDED BY AN UNIDENTIFIED MALE. CHAIRMAN BRODSKY CALLED FOR A VOTE ON MOTION. MOTION PASSED.

Ayes: Babb, Boothe, Brainerd, Brodsky, Carlson, Gale, Haddock, Hampton, Hansen, Hopson, Liljegren, L. Miller, R. Miller, Norman, Polston, Reem, Stables, Stransky, vonHafften, White.
Nays: None.

Meglitinides

Sandy Kapur reviewed the meglitinides, which included Starlix (Nateglinide) and Pradine (Repaglinide). They both stimulate insulin secretion, but unlike the sulfonylureas they have a much faster onset of action and a quarter duration of action. They are used for post-prandial blood sugar control as opposed to fasting blood sugar control. They can be used both as monotherapy in combination with metformin or abloodazones. Prandin has recently altered in its FDA labeling to show a significant drug interaction with Lopex and Atriconizol and concurrent use can increase levels and induce hyperglycemia. Pradin has also been noted to have a drug interaction with arthromisin and viax. Starlix has no significant drug interactions noted in its FDA labeled packaging. Neither agents have an effect on plasma and both agents are cleared. Starlix may have a faster onset of action than Prandin. These agents are not for patients who have failed a second generation sulfonylurea. They work on the same mechanism of action by stimulating insulin secretion. These agents do have a faster onset of action and a shorter duration of action and may cause a decrease in weight gain. These agents may be preferred for patients who require secretagague therapy but have irregular meal schedules. Starlix may have some advantages in the lesser amount of titration that is necessary to dose the agent. These agents are rarely used in the pediatric population and there are no preferences of one agent over the other as both appear to be clinically similar and equivalent.

Dr. Naylor said she used both Pradin and Starlix quite often. They were very useful in people who had irregular meals. They were similar to an analog short acting insulin. The patient can take the medication right before a meal. They are cleared quickly after the meal, so the patient does not have a prolonged period of hunger or hypoglycemia that they might have with sulfonylureas. With Repaglinide you triturate up the dose based on post-prandial. Nateglinide is very useful for people with erratic schedules, because you only use it when you eat. She felt both the meglitinides should be on the preferred drug list.

In response to Janice Stables, Dr. Naylor said she had not experienced any drug interactions with these medications.

ARTHUR HANSEN MOVED TO INCLUDE BOTH PRANDIN AND STARLIX TO THE PREFERRED DRUG LIST. SECONDED BY AN UNIDENTIFIED MALE. CHAIRMAN BRODSKY CALLED FOR A VOTE ON MOTION. MOTION PASSED.

Ayes: Babb, Boothe, Brainerd, Brodsky, Carlson, Gale, Haddock, Hampton, Hansen, Hopson, L. Miller, R. Miller, Norman, Polston, Reem, Stables, Stransky, vonHafften, White.
Nays: Liljegren.

Thiazolidinediones

Sandy Kapur reviewed the thiazolidinediones, Actos (Pioglitazone) and Advandia (Rosiglitazone). Both agents when used as monotherapy decrease lipid 1AC on average 0.5% to 1%. Both agents can be used as monotherapy, with metformin, with sulfonylureas and with insulin. There is debate whether or not Actos decreases lipids more beneficially than Advandia, however that debate has not been truly concluded. At this time there is no known true advantage of one drug over the other. They have the same side effect profile, which appears to be dose related and includes weight gain and fluid retention. The American Heart Association and the American Diabetes Association recently put out a position statement where they stated these drugs should not be used for patients with class superior, class four New York Heart Association heart failure. For patients with class 1 and class 2, they should be used judiciously and used at the lowest dosage range. Whereas metformin and incarbose have been seen in clinical trials to delay the onset of diabetes type 2, Resolin, which was taken off the market in the TRIPOD study, was actually seen to delay the progression of diabetes type 2 for patients with impaired glucose tolerance. The special part of the TRIPOD study was the fact that after Resolin was stopped, it appeared that the actual progression to diabetes type 2 was delayed even further after discontinuation, which lead some to believe that this class not only delays the progression, but delays the onset of diabetes type 2.

Dr. Naylor felt this classification of medications was very important to the treatment of type 2 diabetes. It addresses multiple defects. She felt this had been one of the most positive moves forward they had in years. She thought there was be many more advances in this field over the next five to ten years. It is important to get physicians comfortable with using thiazolidinediones and both Actos and Advandia should be added to the preferred drug list. The side effect profiles are similar. The contraindications are also similar. However, it looks like they not only improve insulin resistance, but they also improve beta cell function and have cardiovascular benefits. The TRIPOD study is being continued as the PIPOD study using poblidizone and it looks like there are some preventative benefits that are sustained in this classification.

In response to Chairman Brodsky, Dr. Naylor said the side effect profiles for the two medications were the same. However, the lipid effects of the two medications seem to be somewhat different. There are independent long-term studies going on looking at the impact of morbidity and mortality from a cardiovascular point of view, which should be available in the next few years.

AN UNIDENTIFIED MALE MOVED TO INCLUDE BOTH ACTOS AND AVANDIA ON THE PREFERRED DRUG LIST. SECONDED BY AN UNIDENTIFIED MALE. CHAIRMAN BRODSKY CALLED FOR A VOTE ON MOTION. MOTION PASSED.

Ayes: 14 voted aye (names not specified).
Nays: 3 voted nay (names not specified), Haddock, Liljegren.

Sandy Kapur discussed the combination products in the thiazolidinediones classification, Avandamet (Rosiglitazone/Metformin), Glucovance (Glyburide/Metformin) and Metaglip (Glipizide/Metformin). There is truly no way to compare these agents with each other. Combination products will be authorized after a patient has been stabilized on two or more agents in order to increase compliance or for patients on multiple agents where compliance is an issue.

Dr. Naylor said she found that changing to a combination agent could be useful when there were compliance problems, but they must be on a stable dose of the combination agents before changing over. She did not have extensive experience with combination agents and did not have a recommendation.

Chairman Brodsky question if people using combination agents were really more compliant than people who were on multiple medications. ANMC avoids combination agents, because there is not really good evidence to show those on combination agents were more compliant and it was more difficult to regulate dosages.

Dr. Naylor said ANMC used Glucovance, which is a combination of Glyburide and Metformin. She felt combination medications were important for some patients, because it reduced the number of pills they had to take.

Chairman Brodsky said there was quite a bit of use of combination medications in the Medicaid system, but a lot of that is due to marketing issues.

David Campana pointed out that any drug that was not added to the preferred drug list could be obtained if the physician wrote the phrase "complex regimen" on the prescription.

MICHELE BOOTHE MOVED TO EXCLUDE ALL THREE BIGUANIDE COMBINATIONS FROM THE PREFERRED DRUG LIST. SECONDED BY AN UNIDENTIFIED FEMALE. CHAIRMAN BRODSKY CALLED FOR A VOTE ON THE MOTION. MOTION PASSED.

Ayes: Babb, Boothe, Brainerd, Brodsky, Carlson, Gale, Haddock, Hampton, Hansen, Hopson, Liljegren, L. Miller, R. Miller, Norman, Polston, Reem, Stables, Stransky, vonHafften, White.
Nays: None.

VII. AGENTS USED IN THE TREATMENT OF HEPATITIS C
Pegylated Interferons

Sandy Kapur said the committee would be only reviewing the pegylated interferons and the regular interferons would not be preferred or non-preferred, but would have open access. The pegylated interferons have only two products available, PEG-Intron, which is Interferon Alpha 2B, and Pegasys, which is Interferon Alfa 2A. Both Alpha 2B and 2A consist of 165 amino acids that are identical with the exception of the one amino acid sequence at position 23. The other difference in these two agents is the actual pegylated moiety attached to the interferon. PEG-Intro has a 12kd PEG moiety attached to the interferon and Pegasys has a 40kd peg moiety attached to the interferon. The differences have not been elucidated so far. Present data suggests that Alpha 2A and 2B have similar response rates and efficacy when given with Ribavirin. The size and branching of the PEG moiety appears to affect tissue distribution, metabolic pathway, and routine of elimination of the parent compound. The improved

responsiveness seen with the pegylated interferons is at least partially related to slower systemic clearance, which means peg interferon alpha 2A may have a theoretical advantage over Peg interferon alpha 2B since it is cleared more slowly from the body. Currently there are no head to head studies of the two agents. The IDEA trial will be the first head to head trial, but it is not believed that this trial will answer the question as to which pegylated interferon is superior. We approached Dr. Brian McMann as a specialist in this category. All of the specialists were sent the informational packet and Dr. Naylor, Dr. Buckley and Dr. McMann has reviewed the information. Dr. McMann reviewed the summary information on hepatitis C pegylated interferons and the ribavirins. He came to the conclusion that one pegylated interferon could be chosen as preferred over the other in light of clinical equivalency. If one is chosen, we recommend grandfathering the patients on current therapy. Dr. McMann did not feel that was needed, but we feel it would make treatments more simplistic.

In response to an unidentified male, Chairman Brodsky said Dr. McMann was one of the world's experts on hepatitis. He travels all over the world, writes about it, conducts trials and treats many hepatitis patients.

Heidi Brainerd said Dr. McMann also works for the Center for Disease Control.

Chairman Brodsky said there were some differences between PEG-Intron and Pegasys in their side effects, tolerance and the ability for people to stay on the treatment. Hepatitis C is a difficult to tolerate the side effects and a lot of people drop out of treatment. Hepatitis C is now the leading cause of liver transplants, so having a treatment for hepatitis C is very important, although it is very expensive. Dr. McMann did not feel there was any proven evidence that showed one of the agents was better than the other. Pegasys provides a steadier amount of drug in the patients system, which some believe is more beneficial in therapy, although it can produce more side effects. Patients may be able to tolerate therapy better using PEG-Intron. There has been no head to head trials to prove this, but there are ongoing trials to obtain more information.

In response to an unidentified male, Sandy Kapur said the treatment for hepatitis C usually lasted about a year.

Diane Liljegren said she spoke with Dr. Thomlin, who is a hematologist at the University of Washington. He believed although there were differences in the peg-interferons, choosing one or the other would be acceptable. She questioned how the issue would be revisited as more information on pegylated interferons were obtained from the trials.

Sandy Kapur said new information could always be brought to the attention of the State or the chairman of the committee. First Health does keep up on the new information. They provide clinical support and assistance and make recommendations to the state when needed. First Health also takes input from the chairman of the committee and the provider community.

ALEXANDER vonHAFFTEN MOVED THAT THE PEGYLATED INTERFERONS WERE EQUIVALENT, HOWEVER PATIENTS WOULD REMAIN ON THE AGENTS THEY CURRENT USED. SECONDED BY AN UNIDENTIFIED MALE. CHAIRMAN BRODSKY CALLED FOR A VOTE ON THE MOTION. MOTION PASSED.

Ayes: Babb, Boothe, Brainerd, Brodsky, Carlson, Gale, Haddock, Hampton, Hansen, Hopson, Liljegren, L. Miller, R. Miller, Norman, Polston, Reem, Stables, Stransky, vonHafften, White.
Nays: None.

Ribavirin

Sandy Kapur reviewed the two Ribavirins, Rebetol and Copegus. Copegus is a Roche product available as a tablet. Rebetol is a Schering-Plough produce available in capsule. The agents are felt to be clinically equivalent and could be interchangeable. First Health does not recommend grandfathering, because the agents can be used interchangeably. Dr. McMann said a generic of Rebetol would soon be available and he felt these agents should be revisited at that time.

GEORGE STANSKY MOVED THAT REBETOL AND COPEGUS WERE EQUIVALENT. SECONDED BY AN UNIDENTIFIED MALE. CHAIRMAN BRODSKY CALLED FOR A VOTE ON THE MOTION. MOTION PASSED.

Ayes: Babb, Boothe, Brainerd, Brodsky, Carlson, Gale, Haddock, Hampton, Hansen, Hopson, Liljegren, L. Miller, R. Miller, Norman, Polston, Reem, Stables, Stransky, vonHafften, White.
Nays: None.

VIII. OPHTHALMIC AGENTS USED IN THE TREATMENT OF GLAUCOMA

Alpha 2 Adrenergic Agents

Sandy Kapur said there were currently three products on the market, Iopdidine, Alphagan P and Brimonidine, which is a generic of Alphagan. Iopdidine at 0.5% has the labeled indication for short-term conjunctive therapy for patients who (indiscernible). Iopdidine at 1% has the FDA labeled indication for the control or prevention of elevation intra-ocular pressure. Alphagan and Alphagan P have FDA indications of lowering intra-ocular pressure for patients with open angle glaucoma for intra-ocular pressure. Although not FDA labeled, Brimonidine has been studied and has been shown to be effective in lowering (indiscernible). It appears that more patients experience more side effects with Brimonidine, but Brimonidine is associated with less frequent ocular side effects.

Chairman Brodsky said those he spoke with felt both the agents were equivalent, but there were fewer side effects with Alphagan P.

GEORGE STRANSKY MOVED THAT THE AGENTS WERE CLINICALLY EQUIVALENT. SECONDED BY TERRY BABB. CHAIRMAN BRODSKY CALLED FOR A VOTE ON THE MOTION. MOTION PASSED.

Ayes: 15 votes aye (persons not identified).
Nays: 3 votes nay (persons not identified), Liljegren.

In response to Terry Babb, Chairman Brodsky said a physician could prescribe one of the non-preferred medications by writing "unacceptable side effects to other agents" on the prescription.

Beta-Blockers

Sandy Kapur reviewed the non-selective and selective beta-blockers. There are currently four non-selective beta-blockers marketed. Carteolol, Levobunolol and Metiprolol is available generically, but Betimol (a formulation of Timolol) is not available generically. The generic cardio-selective agent available is Betaxolol at the 0.5% solution, but Betaxolol at the 0.25% solution is available brand name only. It has been shown that the 0.25% solution versus the 0.5% solution is considered therapeutically equivalent in terms of the magnitude and duration hypotensive effect. All beta-blockers are generally less effective for patients with darker irises. The choice of a specific beta-blocker agent is usually based on differences in the side effect potential and somewhat on patient response, but it is thought that they are equivalent.

In response to Chairman Brodsky, Sandy Kapur said the beta selective agents appear to be slightly less effective than the non-selective agents.

Arthur Hansen (indiscernible -- away from microphone) said Betoptic S 0.5% was the best.

Chairman Brodsky said it was his understanding that they were not using Betoptic anymore, because it had less efficacy than the non-selective agents and more side effects. Those he spoke with favored having Timoptic-XE on the preferred drug list.

TERRY BABB MOVED TO INCLUDE ALL GENERIC PRODUCTS IN THIS CATEGOY ON THE PREFERRED DRUG LIST. SECONDED BY JANICE STABLES. CHAIRMAN BRODSKY CALLED FOR A VOTE ON THE MOTION. MOTION PASSED.

Ayes: Babb, Boothe, Brainerd, Brodsky, Carlson, Gale, Haddock, Hampton, Hansen, Hopson, Liljegren, L. Miller, R. Miller, Norman, Polston, Reem, Stables, Stransky, vonHafften, White.
Nays: None.

Prostaglandin Agonists

Sandy Kapur reviewed the four prostaglandin agonists, Xalatan, Rescula, Travatan and Lumigan. All agents are available as single source brands at this time. Xalatan is the first prostaglandin to receive a first line indication for the initial treatment of elevated intra-ocular pressure, however it is known that all prostaglandin analogues (with the exception of Rescula) are the most potent pharmacological agents for the reduction of IOP in open angle glaucoma and ocular hypertension and are slowly replacing beta-blockers as first line therapy for treatment of glaucoma. There are some possible differences in the response in the African-American population. It has been noted that Travatan and possibly Lumigan may be more effective in the treatment open angle glaucoma in the African-American population. There is not currently a prostaglandin agonists that has an FDA label indication for use in pediatrics. However, these agents have been used and have an impressive IOP lowering in the pediatric population. They also have an excellent safety and side effect profile. It has been noted that outside of the African-American population, all other agents (with the exception of Rescula) compared similarly in the decrease of intra-ocular pressure. It is felt that Rescula is perhaps the weakest of all prostaglandin agonists available. All the other prostaglandin agonists are dosed once daily, but Rescula is dosed twice daily. All others have been shown to decrease intra-ocular pressure by 6 to 8 millimeters on average, whereas Rescula has been shown to lower IOP on average by 3 to 4 millimeters.

An unidentified male said Dr. Gramas (ph) felt Travatan was the best agent.

Chairman Brodsky said those he discussed this with did not feel there was a significant difference. They felt this was the most important group of agents for the treatment of glaucoma and it needed to be included on the preferred drug list. He felt either Lumigan or Travatan on the list, because it worked better in the African-American population. It sounded like Rescula was less effective and required twice a day dosing.

AN UNIDENTIFIED MALE MOVED THAT TRAVATAN BE ADDED TO THE PREFERRED DRUG LIST. SECONDED BY TERRY BABB.

Chairman Brodsky felt the committee should include either Travatan or Lumigan on the preferred drug list, but he also felt the other agents were equivalent and should be placed on the preferred drug list based on their price.

The unidentified male withdrew his motion. Terry Babb withdrew his second.

RICHARD REEM MOVED ACCEPT ALL THE AGENTS, EXCEPT RESCULA, AND INSURE THAT TRAVATAN OR LUMIGAN BE INCLUDED ON THE PREFERRED DRUG LIST. SECONDED BY TERRY BABBY. CHAIRMAN BRODSKY CALLED FOR A VOTE ON THE MOTION. MOTION PASSED.

Ayes: Babb, Boothe, Brainerd, Brodsky, Carlson, Gale, Haddock, Hampton, Hansen, Hopson, Liljegren, L. Miller, R. Miller, Norman, Polston, Reem, Stables, Stransky, vonHafften, White.
Nays: None.

Chairman Brodsky said all the agents would be on the preferred drug list, except Rescula, subject to their price. However, either Travatan or Lumigan will be on the preferred drug list.

Alexander vonHafften pointed out that their method for choosing medications for the preferred drug list was inconsistent.

Chairman Brodsky said the committee generally tried to determine if the drugs were equivalent. The price of the equivalent drugs would then determine which were added to the preferred drug list. In a few of the cases, they have asked for certain drugs to be included on the preferred drug list regardless of the pricing.

Carbonic Anhydrase Inhibitors

Sandy Kapur said there were two available carbonic anhydrase inhibitors, Trusopt and Azopt. There is one combination product, Cosopt. Trusopt and Azopt, which are relatively specific inhibitors of carbonic anhydrase enzyme II, have been clinically shown to decrease intra-ocular pressure by 15% to 26% and appear to be equivalent. It appears that Azopt is claimed to cause less burning and stinging upon instillation than Trusopt due to pH differences in the formulations; however, it is felt that more data is needed before conclusions or claims can be made regarding this special indication. Cosopt is the only combination drug available, but Xalacon will be out in the future.

In response to Diane Liljegren, Sandy Kapur felt the statement that the eyes would only accept one drop at a time and the other drops would "flood" out was valid. She also felt it was impractical to ask a patient to take two or three eye medications at a time. She felt the question should be the clinical equivalency between Azopt and Trusopt.

Chairman Brodsky said those he spoke with felt Azopt and Trusopt were equivalent. Neither of the drugs were great and they both had poor compliance. He felt they should discuss the individual carbonic anhydrase inhibitors first and then discuss the combination product later.

ALEXANDER vonHAFFTEN MOVED THAT AZOPT AND TRUSOPT WERE EQUIVALENT. SECONDED BY AN UNIDENTIFIED MALE. CHAIRMAN BRODSKY CALLED FOR A VOTE ON THE MOTION. MOTION PASSED.

Ayes: Babb, Boothe, Brainerd, Brodsky, Carlson, Gale, Haddock, Hampton, Hansen, Hopson, Liljegren, L. Miller, R. Miller, Norman, Polston, Reem, Stables, Stransky, vonHafften, White.
Nays: None.

Sandy Kapur said they recommended that Cosopt be included on the preferred drug list.

AN UNIDENTIFIED MALE MOVED THAT COSOPT BE INCLUDED ON THE PREFERRED DRUG LIST. SECONDED BY AN UNIDENTIFIED FEMALE. CHAIRMAN BRODSKY CALLED FOR A VOTE ON THE MOTION. MOTION PASSED.

Ayes: Babb, Boothe, Brainerd, Brodsky, Carlson, Gale, Haddock, Hampton, Hansen, Hopson, Liljegren, L. Miller, R. Miller, Norman, Polston, Reem, Stables, Stransky, vonHafften, White.
Nays: None.

VIII. OTHER DISCUSSIONS:

David Campana discussed the implementation of the preferred drug list. Soft edits on the first four classifications of drugs would be at the pharmacies on February 4, 2004. An alert will be sent to the pharmacies when a non-preferred medication is prescribed. At the time of the soft edits, the drugs will not be denied and will be only informational material for the pharmacies. The physician should contact the physician to determine if he wants to change to the preferred drug or provide a medical necessity notation. On April 7, 2004, the hard edits and denials will start. The physician must then note the medical necessity of the non-preferred drug or the pharmacist will call him to determine the medical necessity or have the physician change the drug. General letters were sent out to all practitioners, pharmacists and physicians on our database on December 19, 2003 to introduce the program. On December 31, 2003, we sent separate letters to all pharmacies and physicians describing the program, explaining how non-preferred drugs should be prescribed and the implementation dates. We also sent an initial preferred drug list out, instructions for overriding the alert the pharmacies received and instructions on how providers should prescribe non-preferred drugs. The website includes information on the program, meeting minutes and upcoming meeting agendas. The First Health website contains information for the providers, pharmacies and physicians on how to facilitate the prescriptions being filled. We will do onsite training in Juneau, Anchorage and Fairbanks in the near future. We also have

a quality assurance program. Currently we are reviewing prescribing habits compared to the preferred drugs. We have determined who prescribes the non-preferred drugs and we will be discussing the program with those providers individually. The preferred drug list is on the website and is downloadable to a PDA.

Terry Babb requested that everyone on the committee be sent the letters that were sent to the pharmacies and the physicians.

David Campana said a letter was also sent to all Medicaid recipients explaining the program.

Janice Stables noted that many of the physicians had not received the letters yet.

David Campana said the letters to the providers were sent out on December 31, 2003 by first class mail. They carried both a billing and location address for all providers, but it seemed no matter which address they sent information to, it was the wrong address.

Janice Stables suggested including the information in the Medicaid packet that was sent to providers.

David Campana said the Medicaid packet was sent to the provider's billing address, but some providers used a billing service and did not receive the information.

Chairman Brodsky noted that he had not received either letter and he felt they needed to take a look at that. We really need to sell this program to the physicians and pharmacies, so the information really needs to be sent to the proper address. The next class of drugs discussed will be hermetic antiviral, macrolides, second generation cephalosporins, third generation cephalosporins, onychomycosis antifungals, short acting beta-adrenergics (MDI and Nebs) and long acting beta adrenergics.

Sandy Kapur reviewed the drugs that had been added to the preferred drug list at this meeting. Preferred non-analog insulins: Novolin R, Novolin N and Novolin 70/30, Humulin-L, Lantus, Novolog and Novolog Mix 70/30. Preferred alpha-glucosidas inhibitors: Precose. The committee voted to exclude all three biguanides combinations. Preferred meglitinides: Prandin and Starlix. Preferred pegylated interferon products: Pegasys and Copegus. Preferred alpha 2 adrenergic receptor agonists: Iopdidine, Alphagan P and Brimonidine. Preferred selective and non-selective beta-blockers: all generics. Preferred prostaglandin agonists: Travatan and Lumigan. Preferred carbonic anhydrase inhibitors: Cosopt and Azopt. Preferred second generation sulfonylureas: all generics plus Amaryl.

David Campana said the location of the next Pharmacy and Therapeutics Committee meeting would be at the Frontier building, 8th floor, room 880, on February 13, 2004.

In response to Terry Babb's question on whether all physician provided information could be routed through one person, Chairman Brodsky said they wanted everyone to have the opportunity to talk to someone they knew and trusted. The committee discussed who might be helpful in providing expert information for the next meeting's topics.

Terry Babb asked if the physicians' comments could be provided in writing instead of orally. He also felt it would be beneficial for several physicians to review the drugs and come to a professional agreement that could be recommended to the committee.

The committee further discussed possible physicians to provide expert opinions at the next meeting.

The meeting adjourned at 11:40 a.m.